Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 29, 2015	2015_168202_0018	011319-15	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

BRADFORD VALLEY
2656 6th Line Bradford ON L3Z 3H5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 06, 07, 08, 09, 2015.

Critical Incident (CIS) #2905-000031-15, revealed that the home was investigating a possible medication error that had resulted in resident #01 being sent to hospital on April 30, 2015.

During the course of the inspection, the inspector(s) spoke with director of care, assistant director of care, registered nursing staff, personal support workers.

During the course of the inspection, the inspector reviewed clinical records, the home's
policies related to medication incidents and adverse effects.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #01's progress notes indicated that on an identified date and time, he/she was sent to hospital for treatment and further assessment. The resident returned to the home later on the same identified date, with no new diagnosis. Four days after this date, the home submitted a Critical Incident Report (CIS), to the MOHLTC, indicating that the home was investigating a possible medication error.

An interview with PSW #100 revealed that on the identified date and at an approximate time, he/she found resident #01 in the dining room, in a declined state of health. PSW #100 indicated that at this same time, PSW #103 arrived at the dining room and both PSW's called RPN #106 for assistance.

Interviews with RPN #106, and PSW's #100 and #103 indicated that on the identified date, resident #01's health declined in the dining room. The above mentioned staff indicated that they noticed the resident had an identified item on his/her skin.

PSW #100 and #103 indicated in interviews that it was at this time that RPN #106 became nervous and directed them to remove the identified item from the resident. The PSWs indicated that the identified item was removed immediately and then placed the identified item on the dining room table in front of the resident. Both PSWs further stated that within minutes of placing the identified item on the table, they no longer saw the identified item and assumed that the RPN had removed it.

PSW #100 and PSW #103 further revealed that they were not sure what the identified item had been used for, but knew that the resident does not normally use this item. PSW #100 described the identified item in an interview and indicated that the identified item had a noticeable word printed in its centre. PSW #103 described the identified item in an interview and indicated that there may have been writing on it and that the identified item had not been observed on the resident earlier when he/she had provided care to the resident.

An interview with RPN #106 revealed that he/she did see an identified item on resident #01 after the resident's health declined on the identified date. The RPN indicated that he/she recognized the identified item, and indicated that it may have been a medication. The RPN further indicated that upon noticing the identified item, tried to remove the identified item and when he/she was unable to do so, directed both PSW #100 and #103 to remove it. RPN #106 further revealed that after the identified item had been removed, he/she no longer saw the identified item and denied disposing of it.

PSW #100 indicated in an interview that after the resident had been sent to hospital, RPN #106 approached him/her and stated, "do not say anything". PSW #100 indicated in the interview that he/she did not know what the RPN meant or was referring to at the time. Interviews with PSWs #100 and #103 stated that they did not “feel right" about resident #01 being found with an identified item, or RPN #106's comments and the decline or resident #01's health. Both PSW's indicated that after a discussion with each other, they had decided to report the incident to their regular RPN, on the next scheduled shift three days later.

An interview with RPN #102 revealed that on an identified date, PSW #100 and #103 reported to him/her their concerns of resident #01’s decline in health and finding of an identified item on resident #01, that they believed to be a medication. RPN #102 indicated that because resident #01 does not use the identified item, upon receipt of the information, reported the information immediately to the DOC.

An interview with the DOC indicated that on an identified date, upon receipt of the reported incident received from RPN #102, the home immediately reported to the MOHLTC and initiated an investigated.

The DOC further revealed that as a result of the home’s investigation, confirmed that on an identified date, resident #01 had received a medication that had not been prescribed to the resident, resulting in the resident’s acute decline in health. The DOC stated that the identified item that had been found on resident #01 was believed to be a medication. The DOC revealed that RPN #106 had also failed to report the finding of a medication to the physician, charge nurse, paramedics and family, even though the RPN admitted to seeing it and had asked PSWs to remove it.

The DOC confirmed that RPN #106 has since resigned his/her position with the home and has been reported to the College of Nurses of Ontario.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #01 was found wearing an identified item that is not normally on the resident which resulted in an acute decline in health and transfer to hospital. Direct care staff reported removing the identified item at the time of observation and indicated that it was medicated. Registered staff interviews confirmed that resident #01 did not have an order

for the medicated item. An interview with the DOC and review of home's investigation confirmed that resident #01 was found wearing an identified medicated item on an identified date, that had not prescribed to the resident.

The scope of the non-compliance is isolated to resident #01.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, O.Reg. 79/10. s. 131: A voluntary plan of correction (VPC) was previously issued for s. 131 (5) during a Resident Quality Inspection on April 22, 2014, under Inspection #2014_168202_ 0011. [s. 131. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 138. Absences

Specifically failed to comply with the following:

s. 138. (7) A licensee of a long-term care home shall ensure that when a resident of the home leaves for a medical absence or a psychiatric absence, information about the resident's drug regime, known allergies, diagnosis and care requirements is provided to the resident's health care provider during the absence. O. Reg. 79/10, s. 138 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident of the home leaves for a medical absence or a psychiatric absence, information about the resident's drug regime, known allergies, diagnosis and care requirements is provided to the resident's health care provider during the absence.

Resident #01's clinical records indicated that on an identified date and identified time, he/she was sent to hospital further assessment. The resident returned to the home later on the same identified date, with no new diagnosis. Four days after the identified date, the home submitted a Critical Incident Report (CIS), to the MOHLTC, indicating that the home was investigating a possible medication error.

Interviews with RPN #106, and PSWs #100 and #103 indicated on an identified date, resident #01's condition declined while sitting in the dining room. The above mentioned staff indicated that they noticed that the resident was wearing an identified item that is not normally used by the resident. The identified item was removed immediately by PSW #100 and #103 after receiving direction from RPN #106.

Both PSWs further revealed that within minutes of removing the identified item and placing it on the dining room table, they no longer saw the item and assumed that the RPN had removed it.

PSW #100 and PSW #103 further revealed that they were not sure what the identified item was for, but knew that the resident does not normally wear this identified item. PSW #100 stated that the identified item had a word printed in the centre indicating that it may have been medicated. PSW #103 stated that the identified item may have had writing on it and indicated that the patch had not been observed prior during the resident’s care, for which he/she had provided earlier.

An interview with RPN #106 revealed that he/she did see an identified item on resident #01 at the same time that the resident had a notable decline on an identified date. The RPN indicated that the identified item may have been a medication. The RPN further indicated that upon noticing the identified item, tried to remove the item and when he/she was unable to do so, directed both PSW #100 and #103 to remove it. RPN #106 further revealed that after the identified item had been removed, he/she no longer saw the item and denied disposing of it. RPN #106 then stated that after the identified item had been removed, he/she called the RN in charge for assistance and indicated that he/she had reported the finding of the item to the RN.

An interview with RN #104 indicated that on an identified date and time, found resident #01's health to have acutely declined. The RN indicated that she immediately responded to the resident by providing an assessment and directing RPN #106 to call the family, physician and emergency services.

RN #104 further indicted that once the paramedics arrived at, confirmed with RPN #106 that he/she would provide a report to the paramedics of resident’s #01’s health condition and left the home area. The RN stated that at no time during his/her assistance with resident #01 while in the dining room, did he/she see an identified item or the report that such an item was found.

An interview with RPN #102 revealed that on an identified date, PSW #100 and #103 brought their concerns forward of resident #01's decline and the finding of an identified item on resident #01, that they believed to be a medication. RPN #102 indicated that because resident #01 does not use this type of medication, upon receipt of the information, reported the information immediately to the DOC.

The DOC revealed that as a result of the home's investigation, confirmed that on an identified date, resident #01 had received a medication that had not been prescribed to the resident, resulting in the resident's decline in health and transfer to hospital. The DOC further revealed that although the item found on resident #01 had not been clearly identified, it was believed to be a medication. The DOC revealed that RPN #106 had failed to report the finding of the medication to the physician, charge nurse, paramedics and family, even though the RPN admitted to seeing it and asking PSWs to remove it. The DOC confirmed that RPN #106 has since resigned his/her position with the home and has been reported to the College of Nurses of Ontario.

RPN #106 confirmed in an interview that he/she did not report the finding of the medication that had been found on resident #01 on an identified date, resulting in a transfer to hospital to the physician, family or paramedics. RPN #106 further indicated that he/she did not report the above information to the oncoming health care provider because he/she believed it to be unnecessary given that the medication found on resident #01 had not been included in the resident's current drug regime. [s. 138. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident of the home leaves for a medical absence or a psychiatric absence, information about the resident's drug regime, known allergies, diagnosis and care requirements is provided to the resident's health care provider during the absence, to be implemented voluntarily.

Issued on this 25th day of November, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2015_168202_0018
Log No. / Registre no:	011319-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 29, 2015
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	BRADFORD VALLEY 2656 6th Line, Bradford, ON, L3Z-3H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LUANNE CAMPEAU

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. The plan shall include, but not be limited to, the education of direct care staff on the recognition and awareness for the appropriate use of all identified items used in the home.

The plan shall include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan shall be submitted to valerie.johnston@ontario.ca by November 13, 2015.

Grounds / Motifs :

1. 1. The licensee had failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #01's progress notes indicated that on an identified date and time, he/she was sent to hospital for treatment and further assessment. The resident returned to the home later on the same identified date, with no new diagnosis. Four days after this date, the home submitted a Critical Incident Report (CIS), to the MOHLTC, indicating that the home was investigating a possible medication error.

An interview with PSW #100 revealed that on the identified date and at an approximate time, he/she found resident #01 in the dining room, in a declined state of health. PSW #100 indicated that at this same time, PSW #103 arrived at the dining room and both PSWs called RPN #106 for assistance.

Interviews with RPN #106, and PSWs #100 and #103 indicated that on the

identified date, resident #01's health declined in the dining room. The above mentioned staff indicated that they noticed the resident had an identified item on his/her skin.

PSW #100 and #103 indicated in interviews that it was at this time that RPN #106 became nervous and directed them to remove the identified item from the resident. The PSWs indicated that the identified item was removed immediately and then placed the identified item on the dining room table in front of the resident. Both PSWs further stated that within minutes of placing the identified item on the table, they no longer saw the identified item and assumed that the RPN had removed it.

PSW #100 and PSW #103 further revealed that they were not sure what the identified item had been used for, but knew that the resident does not normally use this item. PSW #100 described the identified item in an interview and indicated that the identified item had a noticeable word printed in its centre. PSW #103 described the identified item in an interview and indicated that there may have been writing on it and that the identified item had not been observed on the resident earlier when he/she had provided care to the resident.

An interview with RPN #106 revealed that he/she did see an identified item on resident #01 after the resident's health declined on the identified date. The RPN indicated that he/she recognized the identified item, and indicated that it may have been a medication. The RPN further indicated that upon noticing the identified item, tried to remove the identified item and when he/she was unable to do so, directed both PSW #100 and #103 to remove it. RPN #106 further revealed that after the identified item had been removed, he/she no longer saw the identified item and denied disposing of it.

PSW #100 indicated in an interview that after the resident had been sent to hospital, RPN #106 approached him/her and stated, "do not say anything". PSW #100 indicated in the interview that he/she did not know what the RPN meant or was referring to at the time. Interviews with PSW's #100 and #103 stated that they did not “feel right" about resident #01 being found with an identified item, or RPN #106's comments and the decline or resident #01's health. Both PSWs indicated that after a discussion with each other, they had decided to report the incident to their regular RPN, on the next scheduled shift three days later.

An interview with RPN #102 revealed that on an identified date, PSW #100 and

#103 reported to him/her their concerns of resident #01's decline in health and finding of an identified item on resident #01, that they believed to be a medication. RPN #102 indicated that because resident #01 does not use the identified item, upon receipt of the information, reported the information immediately to the DOC.

An interview with the DOC indicated that on an identified date, upon receipt of the reported incident received from RPN #102, the home immediately reported to the MOHLTC and initiated an investigated.

The DOC further revealed that as a result of the home's investigation, confirmed that on an identified date, resident #01 had received a medication that had not been prescribed to the resident, resulting in the resident's acute decline in health. The DOC stated that the identified item that had been found on resident #01 was believed to be a medication. The DOC revealed that RPN #106 had also failed to report the finding of a medication to the physician, charge nurse, paramedics and family, even though the RPN admitted to seeing it and had asked PSWs to remove it.

The DOC confirmed that RPN #106 has since resigned his/her position with the home and has been reported to the College of Nurses of Ontario.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #01 was found wearing an identified item that is not normally on the resident which resulted in an acute decline in health and transfer to hospital. Direct care staff reported removing the identified item at the time of observation and indicated that it was medicated. Registered staff interviews confirmed that resident #01 did not have an order for the medicated item. An interview with the DOC and review of home's investigation confirmed that resident #01 was found wearing an identified medicated item on an identified date, that had not prescribed to the resident.

The scope of the non-compliance is isolated to resident #01.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, O.Reg. 79/10. s. 131: A voluntary plan of correction (VPC) was previously issued for s. 131 (5) during a Resident

Quality Inspection on April 22, 2014, under Inspection #2014_168202_ 0011. [s. 131. (1)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

Service Area Office /
Bureau régional de services : Toronto Service Area Office